



# VIRTUAL GATEWAY

Common Intake Process  
MassHealth



Cover Sheet

APPLICATION DATE: \_\_\_\_\_

APPLICATION NUMBER: \_\_\_\_\_

NO. OF PAGES ATTACHED:  
(Including this sheet)

## Facility Information

Facility Name: \_\_\_\_\_

Sender's Phone No: \_\_\_\_\_

Sender's Name: \_\_\_\_\_

## Head of Household (HOH) Information

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Soc. Sec. No: \_\_\_\_\_

Please include this cover sheet when faxing or mailing any documents to MassHealth. Verifications should always be faxed. Signature pages (two-page applicant's signature pages, absent parent assignment of rights pages, ERD signature page, PSI signature page, PCA signature pages, and DDU supplements) should always be mailed.

Verifications should be faxed within three business days from the date of the application to avoid a delay in processing to the CPU, or to the appropriate MEC if ANY applicant is age 65 or older and not a parent/caretaker relative of a child under 19. For all applications where applicant is under age 65, after three business days have passed, please fax verifications to 617-241-3299 using the "HCR Intake Verification Unit Fax Cover Sheet." For those applications where ANY applicant is age 65 or older and not a parent/caretaker relative of a child under 19, please fax verifications to the appropriate MEC. Signature papers must be mailed to the MEC or CPU, as appropriate.

## FAX NUMBERS

CPU: 617-241-6020

Springfield MEC: 413-785-4179

Revere MEC: 781-485-3405

Taunton MEC: 508-828-4737

Tewksbury MEC: 978-863-9217

Place a checkmark ( ✓ ) in the appropriate space below identifying the attached verification(s) or signature pages.

\_\_\_\_\_ Income – FAX ONLY

\_\_\_\_\_ Immigration – FAX ONLY

\_\_\_\_\_ Citizenship and/or Identity – FAX ONLY (Required ONLY for applicants who claim to be a U.S. citizen/national)

\_\_\_\_\_ Assets (bank accounts, stocks, bonds, life insurance, etc): ONLY for applications containing ANY applicants age 65 or older and not a parent/caretaker relative of a child under 19 – FAX ONLY

\_\_\_\_\_ Other Health Insurance (other than Medicare) – FAX ONLY

\_\_\_\_\_ DDU Supplement—ORIGINAL – MAIL ONLY

\_\_\_\_\_ PSI (Permission to Share Form) – MAIL ONLY

\_\_\_\_\_ ERD (Eligibility Referral Designation)—ORIGINAL – MAIL ONLY

\_\_\_\_\_ Signature pages—ORIGINAL, 2-page – MAIL ONLY

\_\_\_\_\_ Other \_\_\_\_\_

*This facsimile transmittal may contain information that is privileged, confidential, or exempt from disclosure under applicable law is intended for the use of only the individual or department to which it is addressed. If you are not the recipient, or the employee or the agent responsible for the delivery of this transmittal to the intended recipient, please notify the sender by telephone at the above number and destroy the attached documents. Anyone other than the intended recipient is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.*



## VIRTUAL GATEWAY

Common Intake Process MassHealth  
MassHealth

### Change of Information Form

APPLICATION NUMBER:

DATE:

#### Facility Information

User ID: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Sender's Phone No: \_\_\_\_\_

Sender's Name: \_\_\_\_\_

#### Head of Household (HOH) Information

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Soc. Sec. No: \_\_\_\_\_

In order to make corrections to data on the Common Intake Tool, this form must be completed and faxed to either the CPU or the appropriate MEC, depending on the type of MassHealth application it is and when you are sending this form. CPU's fax number is 617-241-6020. MEC fax numbers are: Revere MEC: 781-485-3405 / Taunton MEC: 508-828-4737 / Springfield MEC: 413-785-4179 / Tewksbury MEC: 978-863-9217

#### **Please change the following information:**

HEAD OF HOUSEHOLD (HOH): *Place checkmark ✓ beside each item and complete.*

1. ☐ HOH Name \_\_\_\_\_  
☐ HOH Address \_\_\_\_\_  
☐ HOH Birth date \_\_\_\_\_  
☐ HOH SS No. \_\_\_\_\_  
☐ Other HOH Information \_\_\_\_\_

OTHER FAMILY MEMBERS: *Place checkmark ✓ beside each item and complete.*

2. ☐ Family Member's Name \_\_\_\_\_  
☐ Address \_\_\_\_\_  
☐ Birth date \_\_\_\_\_  
☐ SS No. \_\_\_\_\_  
☐ Other Information \_\_\_\_\_
3. ☐ Family Member's Name \_\_\_\_\_  
☐ Address \_\_\_\_\_  
☐ Birth date \_\_\_\_\_  
☐ SS No. \_\_\_\_\_  
☐ Other Information \_\_\_\_\_
4. ☐ Family Member's Name \_\_\_\_\_  
☐ Address \_\_\_\_\_  
☐ Birth date \_\_\_\_\_  
☐ SS No. \_\_\_\_\_  
☐ Other Information \_\_\_\_\_

☐ **OTHER INFORMATION CHANGES:** *Describe other requested changes.*

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